Health Canada Santé Canada

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Federal Monitoring of Medical Assistance in Dying

Physician/Nurse Practitioner Form

Instructions:

You must report if you are a physician or nurse practitioner (referred to collectively as "practitioners") who has received a request for medical assistance in dying (MAID) **in writing** and encountered one of the scenarios listed in the table below. Use this form if you are a physician or nurse practitioner in Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Quebec or the Yukon. Also use this form if you are in Ontario and reporting on a case that did not involve a MAID death. For other provinces and territories or if you are reporting a MAID death in Ontario, please consult Health Canada's website for further information about where to report. In addition, this form is only for use when a physician or nurse practitioner is unable to use the Canadian MAID Data Collection Portal (e.g. no Internet access).

What type of request triggers the requirement to report?

The regulations require written requests to be reported in certain situations outlined below. A patient's written request may take any form including a text message or an e-mail. It must, however, be more than an inquiry or a request for information about MAID. The request **does not have to be** in the format required by the *Criminal Code* as a safeguard when MAID is provided (i.e., duly signed, dated and witnessed) to require reporting.

Scenario	Deadline to report	Related rules
Scenario 1: You provided MAID by administering a substance to a patient	Within 30 days after the day the patient dies	
Scenario 2: You provided MAID by prescribing or providing a substance for self-administration by the patient	Between 90–120 days	You can report earlier if you know the patient has died. In all other cases, you must wait 90 days before reporting.
Scenario 3: You referred a patient to another practitioner or a care coordination service or transferred their care as a result of the request	Within 30 days after the day of referral/transfer	You do not need to report if you refer or transfer a patient more than 90 days after the day you receive the written request. If you report with respect to a referral or transfer of care, you are not required to report again for the same written request unless you later provide MAID.

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Scenario 4: You found a patient to be ineligible for MAID	Within 30 days after the day ineligibility is determined	You do not need to report if you find a patient ineligible more than 90 days after the day you receive the written request. If you report on a finding of ineligibility, you are not required to report again for the same written request unless you later provide MAID.
Scenario 5: You became aware that the patient withdrew the request for MAID	Within 30 days after the day you became aware of the withdrawal	You do not need to report if you become aware that a patient withdrew their request more than 90 days after the day you receive the written request. If you report on the withdrawal of a request, you are not required to report again for the same written request unless you later provide MAID. You are not required to actively seek out information about whether the patient has withdrawn the request, whether or not you have assessed them. In such a situation, you do not need to report.
Scenario 6: You became aware of the death of the patient from a cause other than MAID	Within 30 days after the day you became aware of the patient's death	You do not need to report if you become aware that a patient has died of a cause other than MAID more than 90 days after the day you receive the written request. You are not required to actively seek out information about whether the patient has died of a cause other than MAID, whether or not you have assessed them. In such a situation, you do not need to report.

For further information, see the *Guidance Document on Reporting Requirements under the Regulations for the Monitoring of Medical Assistance in Dying.*

Section 1: Basic Information

To be completed in all cases.

1a. Patient Information

Personal information is required in order to link information which relates to the same patient. It also assists Health Canada in understanding trends in the requesting and provision of MAID and to make linkages with other data sets to limit what is requested of the practitioner.

Date of birth (YYYY/MM/DD)	Sex ☐ Male ☐ Female ☐ X *Select X if the patient does not identity as male or female.*	Health insurance number ☐ Not applicable

Province or territory that issued the health insurance number *If the patient does not have a health insurance number, please indicate the province or territory of their usual place of residence on the day the practitioner received the written request.*	Postal code associated with the patient's health insurance number *If the patient does not have a health insurance number, please indicate the postal code of their usual place of residence on the day the practitioner received the written request.*

1b. Practitioner Information

Personal information regarding the practitioner is collected to be able to follow up for clarification or to seek missing information.

Name (first and last)

Province or territory where you received the patient's writtten request for MAID

Are you a (choose one): ☐ Physician ☐ Nurse practitioner	If you are a physician, what is your area of specialty: ☐ Anaesthesiology ☐ Cardiology ☐ Family medicine ☐ General internal medicine ☐ Geriatric medicine ☐ Nephrology ☐ Neurology ☐ Oncology ☐ Palliative medicine ☐ Respiratory medicine ☐ Other - specify:	Licence or registration number *If you practice in more than one province or territory, please indicate the licence or registration number for the province or territory in which you received the written request for MAID. This number is the one attributed to you by your College, not your billing number.* To the best of your knowledge or belief, before you received the written request for MAID, did the patient consult you concerning their health for a reason other than seeking MAID? ☐ Yes ☐ No

Provide the mailing address at your primary place of work	Provide the e-mail address that you use for work

1c. Receipt of the Written Request

From whom did you receive the written request for MAID that triggered the reporting requirement? ☐ Patient directly ☐ Another practitioner ☐ Care coordination service ☐ Another third party- specify:	Date of receipt of written request for MAID (YYYY/MM/DD)

Section 2: Referring or Transferring the Care of a Patient

Only complete if you are providing information about a referral or a transfer of care which is the result of a MAID request.

Date of referral or transfer of care (YYYY/MM/DD)	Did you complete an eligibility assessment prior to referring the patient or transferring their care? ☐ Yes ☐ No **If yes,** was the patient eligible for MAID, in your opinion? ☐ Yes ☐ No

Did you refer the patient elsewhere or transfer their care for any of the following reasons (select all that apply):

☐ Due to policies on MAID of a hospital, residential care facility or palliative care facility where the patient is located
☐ Assessing or providing MAID is contrary to your conscience or beliefs
☐ Due to lack of relevant expertise to provide MAID
☐ Due to patient's request

OR

☐ None of the above

Section 3: Eligibility Criteria and Related Information

To be completed if:

a) you provided MAID;
b) you found the patient to be ineligible for MAID;
c) the patient withdrew the request after you found them to be eligible for MAID, or
d) you became aware of the patient's death from a cause other than MAID after you found them to be eligible for MAID.

The following section lists the eligibility criteria as per the Criminal Code, and asks you to indicate whether you assessed it and, if so, your opinion as to the patient's eligibility, with relevant details where specified.

A practitioner will not necessarily assess all criteria for every request. If a patient is ineligible based on one criterion, the practitioner may not have assessed the remaining criteria.

Eligibility Criteria		If you assessed the criterion, provide relevant details, where indicated
Was the patient eligible for health services funded by a government in Canada? *Answer "Yes" if the patient would have been eligible but for an applicable minimum period of residence or waiting period.*	☐ Yes ☐ No ☐ Did not assess	
Was the patient at least 18 years of age?	☐ Yes ☐ No ☐ Did not assess	
Was the patient capable of making decisions with respect to their health?	☐ Yes ☐ No ☐ Did not assess	

Did the patient make a voluntary request for MAID that, in particular, was not made as a result of external pressure?	☐ Yes ☐ No ☐ Did not assess	**If yes,** indicate why you are of this opinion (select all that apply): ☐ Consultation with patient ☐ Knowledge of patient from prior consultations or treatment for reasons other than MAID ☐ Consultation with other health or social service professionals ☐ Consultation with family members or friends ☐ Reviewed medical records ☐ Other- specify:
Did the patient give informed consent to receive MAID after having been informed of the means that were available to relieve their suffering, including palliative care[1]?	☐ Yes ☐ No ☐ Did not assess	
Did the patient have a serious and incurable illness, disease or disability?	☐ Yes ☐ No ☐ Did not assess	**If yes,** indicate the serious and incurable illness, disease or disability (select all that apply): ☐ Cancer – lung and bronchus ☐ Cancer – breast ☐ Cancer – colorectal ☐ Cancer – pancreas ☐ Cancer – prostate ☐ Cancer – ovary ☐ Cancer – hematologic ☐ Cancer – other. Specify: ☐ Neurological condition – multiple sclerosis ☐ Neurological condition – amyotrophic lateral sclerosis ☐ Neurological condition – other *(For stroke, select cardio-vascular condition, not neurological condition- other).* Specify: ☐ Chronic respiratory disease (e.g., chronic obstructive pulmonary disease) ☐ Cardio-vascular condition (e.g., congestive heart failure, stroke). Specify: ☐ Other organ failure (e.g., end-stage renal disease) ☐ Multiple co-morbidities. Specify: ☐ Other serious and incurable illnesses, diseases or disabilities. Specify:

[1] Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of pain and other physical symptoms, and psychosocial and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.

Was the patient in an advanced state of irreversible decline in capability?	☐ Yes ☐ No ☐ Did not assess	
Did the patient's illness, disease or disability, or their state of decline cause them enduring physical or psychological suffering that was intolerable to them and could not be relieved under conditions that they considered acceptable?	☐ Yes ☐ No ☐ Did not assess	**If yes,** indicate how the patient described their suffering (select all that apply): ☐ Loss of ability to engage in activities making life meaningful ☐ Loss of dignity ☐ Isolation or loneliness ☐ Loss of ability to perform activities of daily living (e.g. bathing, food preparation, finances) ☐ Loss of control of bodily functions ☐ Perceived burden on family, friends or caregivers ☐ Inadequate pain control, or concern about it ☐ Inadequate control of other symptoms, or concern about it ☐ Other. Specify:
Had the patient's natural death become reasonably foreseeable, taking into account all of their medical circumstances?	☐ Yes ☐ No ☐ Did not assess	
Other Information		
Did you consult with other health care professionals, such as a psychiatrist or the patient's primary care provider, or social workers to inform your assessment (do not include the mandatory written second assessment required by the *Criminal Code*)? ☐ Yes ☐ No		**If yes,** indicate what type of professional you consulted (select all that apply): ☐ Nurse ☐ Oncologist ☐ Palliative care specialist ☐ Primary care provider ☐ Psychiatrist ☐ Psychologist ☐ Social worker ☐ Speech pathologist ☐ Other health care professionals-specify:

Did the patient receive palliative care[2]? ☐ Yes ☐ No ☐ Do not know **If yes**, for how long? ☐ Less than 2 weeks ☐ 2 weeks to less than 1 month ☐ 1-6 months ☐ more than 6 months ☐ Do not know **If no**, to the best of your knowledge or belief, was palliative care accessible to the patient? ☐ Yes ☐ No ☐ Do not know	Did the patient **require** disability support services[3]? ☐ Yes ☐ No ☐ Do not know **If yes**, did the patient **receive** disability support services? ☐ Yes ☐ No ☐ Do not know **If yes**, for how long? ☐ Less than 6 months ☐ 6 months to less than 1 year ☐ 1 to less than 2 years ☐ 2 years or more ☐ Do not know **If no**, to the best of your knowledge or belief, were disability support services accessible to the patient? ☐ Yes ☐ No ☐ Do not know

Section 3b: Change in Eligibility

To be completed if, in your opinion, the patient was NOT eligible.

Had you previously determined that the patient was eligible for MAID?

☐ Yes ☐ No

If yes, was the patient's change in eligibility due to the loss of capacity to make decisions with respect to their health?

☐ Yes ☐ No

If yes, did you become aware that the patient's request was not voluntary (e.g. based on new information regarding external pressure)?

☐ Yes ☐ No

Section 4: Procedural Requirements – Providing MAID

Only complete if you provided MAID.

The following section relates to the safeguards as per the Criminal Code. Please place a check mark (✓) in the middle column where appropriate, and provide relevant details where indicated.

Safeguards as per the Legislation	✓	Relevant Details (where indicated)
I was of the opinion that the patient **met all of the eligibility criteria**. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(a).*		
I ensured that the patient's request for MAID was made in **writing and signed and dated** by the patient, or by another person permitted to do so on their behalf.[4] *Relevant subsections of the Criminal Code: 241.2(3)(b)(i) and 241.2(4).*		**If checked**, indicate the date on which the patient (or other person) signed the request (YYYY/MM/DD)

[2] Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of pain and other physical symptoms, and psychosocial and spiritual suffering. It may be provided in any setting, by specialists or by others who have been trained in the palliative approach to care.

[3] Disability support services could include but are not limited to assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability-based income supplements.

[4] This requirement refers to the more formal written request which is a legislative safeguard and must be signed, dated and witnessed. To trigger an obligation to report, a written request need not be signed, dated and witnessed.

I ensured that the request was **signed and dated after the patient was informed** by a physician or nurse practitioner that the patient had a **grievous and irremediable medical condition.** *Relevant subsection of the Criminal Code: 241.2(3)(b)(ii).*		
I was satisfied that the request was signed and dated by the patient or by another person permitted to do so on their behalf, and **before two independent witnesses** who then signed and dated the request. *Relevant subsections of the Criminal Code: 241.2(3)(c), 241.2(4) and 241.2(5).*		
I ensured that the patient was **informed that they may**, at any time and in any manner, **withdraw their request.** *Relevant subsection of the Criminal Code: 241.2(3)(d).*		
I ensured that another physician or nurse practitioner provided a written opinion (**second assessment**) confirming that the patient met all of the criteria. *Relevant subsections of the Criminal Code: 241.2(1) and 241.2(3)(e).*		**If checked**, please indicate whether the practitioner who provided a second opinion (second assessment) was a: ☐ Physician or ☐ Nurse practitioner On what date did the other practitioner sign their written opinion? (YYYY/MM/DD)
I was satisfied that the other **practitioner and I are independent.** *Relevant subsections of the Criminal Code: 241.2(3)(f) and 241.2(6).*		
I ensured that there were at least **10 clear days** between the day on which the request was signed by or on behalf of the patient and the day on which MAID was provided. *Clear days include weekends. In calculating the 10 clear days, the day on which the request was signed and the day on which MAID was provided will not be included. The legislation permits shortening the reflection period in appropriate circumstances.* *Relevant subsection of the Criminal Code: 241.2(3)(g).*		Where you considered a shorter period than 10 clear days appropriate in the circumstances, was it the patient's death or loss of capacity to provide informed consent that was deemed imminent (select all that apply)? ☐ Patient's death ☐ Patient's loss of capacity to provide informed consent
Immediately before providing MAID, I gave the patient an **opportunity to withdraw** their request and ensured that the patient gave express consent to receive MAID. *Relevant subsection of the Criminal Code: 241.2(3)(h).*		
If the patient had **difficulty communicating**, I took all necessary measures to provide a reliable means by which the patient could have understood the information that was provided to them and communicated their decision. *If the patient did not have difficulty communicating, indicate "n/a" in the next column.* *Relevant subsection of the Criminal Code: 251.2(3)(i).*		
I **informed the pharmacist**, before the pharmacist dispensed the substance that I prescribed or obtained, that the substance was intended for the purpose of providing MAID. *Relevant subsection of the Criminal Code: 241.2(8).*		

Section 5: Prescribing or Providing a Substance to the Patient for the Purpose of Self-Administration

Only complete if you prescribed or provided a substance for self-administration.

Date of prescribing or providing the substance (YYYY/MM/DD)

If you both prescribed and provided the substance, use the date that you prescribed.

Where was the patient staying when you prescribed or provided the substance :

- ☐ Hospital (exclude palliative care beds or unit)
- ☐ Palliative care facility (include hospital-based palliative care beds, unit, or hospice)
- ☐ Residential care facility (include long-term care facilities)[5]
- ☐ Private residence
- ☐ Other-specify:

☐ Do not know

Did the patient self-administer the substance (i.e. the substance was ingested)

☐ Yes ☐ No ☐ Do not know *(do not answer questions 5a or b if you answered "do not know")*

5a: If the patient did self-administer the substance, indicate:

Were you present when the patient self-administered the substance?

☐ Yes ☐ No

On what date did the patient self-administer the substance? (YYYY/MM/DD)

☐ Do not know

Note that you are not required to actively seek out this information, but must report if known at the time of reporting.

Where did the patient self-administer the substance:

- ☐ Hospital (exclude palliative care beds or unit)
- ☐ Palliative care facility (include hospital-based palliative care beds, unit, or hospice)
- ☐ Residential care facility (include long-term care facilities)[5]
- ☐ Private residence
- ☐ Other- specify:

☐ Do not know

Note that you are not required to actively seek out this information, but must report if known at the time of reporting.

5b: If the patient did not self-administer the substance, to the best of your knowledge or belief, indicate:

Did the patient die of a cause other than MAID?

☐ Yes ☐ No ☐ Do not know

If yes, provide the date of death: (YYYY/MM/DD)

☐ Do not know

Note that you are not required to actively seek out this information, but must report if known at the time of reporting.

[5] Residential care facility means a residential facility that provides health care services, including professional health monitoring and nursing care, on a continuous basis for persons who require assistance with the activities of daily living.

Section 6: Administering a Substance to the Patient

Only complete if you administered a substance to the patient.

On what date did you administer the substance?
(YYYY/MM/DD)

Where did you administer the substance?

☐ Hospital (exclude palliative care beds or unit)
☐ Palliative care facility (include hospital-based palliative care beds, unit, or hospice)
☐ Residential care facility[6] (include long-term care facilities)
☐ Private residence
☐ Other- specify:

Section 7: Withdrawal of Request

Only complete if you became aware that the patient withdrew his or her request.

For the purposes of monitoring, "withdrew the request" means that, to the best of the practitioner's knowledge, the patient does not intend to pursue their request for medical assistance in dying. The withdrawal may take any form (.e.g., oral or in writing). A lack of contact with the patient would not be sufficient to assume that he or she had withdrawn the request and would not require the provision of information. You are not required to actively seek out information about whether the patient has withdrawn their request, but must report if known at the time of reporting.

What were the patient's reasons for withdrawing the request (select all that apply):

☐ Palliative measures are sufficient
☐ Family members do not support MAID
☐ Changed their mind
☐ Other- specify:

☐ Do not know

Did the patient withdraw their request after being given an opportunity to do so immediately before providing MAID, as per Section 241.2(3)(h) of the *Criminal Code*?

☐ Yes ☐ No

Section 8: Patient Died of Cause other than Medical Assistance in Dying

Only complete if you became aware that the patient died of a cause other than MAID and you had not prescribed or provided a substance for self-administration. You are not required to actively seek out information about whether the patient has died of a cause other than MAID, but must report if known at the time of reporting.

Did you complete the death certificate?

☐ Yes ☐ No

If yes, what was the date of death?
(YYYY/MM/DD)

What is the immediate cause of death indicated on the death certificate?

What is the underlying cause of death indicated on the death certificate?

If no, provide the date of death
(YYYY/MM/DD)

☐ Do not know

[6] Residential care facility means a residential facility that provides health care services, including professional health monitoring and nursing care, on a continuous basis for persons who require assistance with the activities of daily living.

Section 9: Supplementary information

Provide supplementary information to clarify your responses, if applicable.

Please send to:

End-of-life Care Unit
Strategic Policy Branch
Health Canada
200 Eglantine Driveway, 4th Floor, Room 411A
Tunney's Pasture
Ottawa, ON K1A 0K9

Toll free fax number: 1-833-219-0422

PRIVACY NOTICE

The personal information that you provide is protected and governed in accordance with the *Privacy Act*. Health Canada will only collect the personal information needed to administer the Monitoring of Medical Assistance in Dying Program authorized under the *Monitoring of Medical Assistance in Dying Regulations*.

Purpose of collection: Health Canada requires your personal information as per mandatory reporting requirements under sections 241.31(1), 241.31(2) and 241.31(3) of the *Criminal Code*, and the *Regulations for the Monitoring of Medical Assistance in Dying* for the primary purpose of monitoring medical assistance in dying requests and their outcomes.

Other uses or disclosures: Your personal information and the personal information of your patient may be shared with your province or territory or authorized public body or institution for monitoring purposes. Your personal information and personal information of your patient will also be disclosed to Statistics Canada in accordance with the *Statistics Act* for research and statistical purposes to help federal, provincial and territorial ministries of health and justice better understand and address issues associated with the implementation of medical assistance in dying in Canada. Statistics Canada is prohibited by law from releasing any information it obtains which could identify any person, business, or organization, unless consent has been given or as permitted by the *Statistics Act*. Personal information provided may be linked to existing Statistics Canada or Health Canada data sources (such as socio-economic data in a specified geographical location) to provide a broader picture of assisted dying in Canada.

In limited and specific situations, your personal information may be disclosed without your consent in accordance with subsection 8(2) of the *Privacy Act*.

Refusal to provide the information: Failure to provide the information and/or adhere to prescribed timelines is an offence as prescribed under section 241.3(a) and 241.3(b) of the *Criminal Code*.

For more information: A Personal Information Bank (PIB) is under development and will be included in Info Source available online at https://www.canada.ca/en/health-canada/corporate/about-health-canada/activities-responsibilities/access-information-privacy/info-source-federal-government-employee-information.html.

Your rights under the *Privacy Act*: In addition to protecting your personal information, the *Privacy Act* gives you the right to request access to and correct your personal information. For more information about these rights, or about our privacy practices, please contact Privacy Management Division at privacy-vie.privee@hc-sc.gc.ca. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

For more information about the Medical Assistance in Dying Program, please contact hc.maid.report-rapport.amm.sc@canada.ca.